

CITY OF HIALEAH, FLORIDA
RISK MANAGEMENT DIVISION
MEMORANDUM

To: All retired General and Confidential Employees and Retired Firefighters Currently Enrolled in the City Self-Funded Plan or HMO

From: Robert Lloyd-Still, Risk Manager *RLS*

Date: October 31, 2012

Subject: Open Enrollment/ Rates for Group Health Insurance

The time is coming when the City of Hialeah conducts its annual open enrollment for the various insurance programs offered through the City: COH Self-Funded Plan, HMO, Dental coverage, Vision coverage, GAP coverage, or the other supplementary programs. During this time, you are able to update the coverages that best fit your needs. With regards to the HMO, AFSCME has executed a contract with Coventry Healthcare to continue with the two benefit options with new rates and with some benefit modifications. The City was reimbursed \$88,640.23 for the HMO under the early retiree reinsurance program this year, and the \$88,640.23 will be used by increasing the City's HMO contribution by \$11.00 monthly for single, double, or family coverage. Under the City's Self-Funded Plan, there are changes to the rates and some benefit modifications. Under the City's Self-Funded Plan, there are changes to the rates and some benefit modifications. The new rates for each of the programs are attached. The changes to the benefits under the COH Self-Funded Plan are as follows: an increase in the co-payments for specialist physician office visits and emergency health services, and new deductibles for prescriptions and in-network hospital care.

The enrollment period will begin on Monday, December 3, 2012, and end on Friday, December 7, 2012 at 4:00 PM. Please note that the period to make insurance changes ends on Friday, December 7, 2012.

COH Self-Funded Plan pays benefits second if you are eligible for Medicare even if you choose not to elect Medicare

Under the COH Self-Funded Plan, when an individual qualifies for Medicare, the Plan will pay benefits second to Medicare. This applies to every retiree that is eligible for Medicare whether you are approaching the age of 65 or if you are disabled and eligible for Medicare benefits. This condition is in place even if you choose not to elect Medicare. (*However, the Plan pays benefits first and Medicare pays benefits second for individuals with end-stage renal disease, for a limited period of time.*) Therefore, if you are eligible for Medicare and choose not to enroll, the COH Plan will pay benefits as if you had enrolled under Medicare.

Dependent Eligibility

The City has been advised to conduct a dependent audit/verification. This is being done in order to manage overall healthcare costs by confirming that only *eligible* dependents are enrolled in the City's health insurance programs. Removing ineligible dependents helps control costs for *all* plan participants. However, before conducting the dependent audit/verification, the City would like to update its records. **The City is looking to remove any dependents that are no longer eligible for the City's plans, i.e. ineligible spouses because of divorce or ineligible children because of changes in child custody status. Currently there is no penalty for removing ineligible dependents. Should ineligible dependents remain on the plans after the dependent audit/verification, the City will require payment for any past insurance claims that the plans have incurred on behalf of these ineligible dependents. In the event there is a willful misrepresentation for coverage purposes, the retiree shall be subject to loss of their own insurance coverage.**

Anyone who desires to make a change must do so during the open enrollment, and you must remain within that plan until the next open enrollment scheduled by the City of Hialeah. Please see the attached schedule of benefits for the two different options being offered by Coventry Healthcare. Please see the attached summary sheet from United Healthcare that highlights the City's Self-Funded Plan. If you decide to add or remove dependents in the City's Self-Funded Plan, you may do so through the City's Risk Management Office located on the third floor of City Hall. All changes will become effective January 1, 2013.

If you have any questions regarding any of the above information, please call the Risk Management Office at (305) 883-8059 or (305) 883-8048. A Coventry Healthplan representative can be reached at (888) 679-9148, between the hours of 8:30 am - 5:00 pm. Also, if you have questions concerning the dental and/or vision coverage, you can speak with a Humana representative directly at (800) 342-5209. Please visit the Risk Management Page of the City's website at www.hialeahfl.gov to view the Summary Plan Descriptions and other descriptions or updates regarding the City's different insurance programs. Also, open enrollment is an opportunity to update your beneficiary forms for the City's life insurance programs at Risk Management.

**CITY OF HIALEAH, FLORIDA
RISK MANAGEMENT DIVISION
MEMORANDUM**

Para: **Todo Empleado Jubilado General, y Confidencial
Actualmente inscritos en el Plan de la Ciudad Self-Funded o HMO**

De: **Robert Lloyd-Still, Risk Manager**

Fecha: **Octubre 31, 2012**

Referente: **Inscripción abierta/Tarifas para Seguros de Salud de Grupos**

El momento ha llegado para la Ciudad de Hialeah de llevar a cabo su enrolamiento anual abierto para los diferentes programas de seguros ofrecidos por la Ciudad. COH Self-Funded Plan HMO, cobertura Dental, de Visión, y de GAP u otros planes complementarios. Durante este tiempo es el momento de actualizar las coberturas que mejor se adapten a sus necesidades. Con respecto al HMO AFSCME ha ejecutado un contrato con Coventry Healthcare para continuar con las opciones de dos beneficios. La ciudad fue reembolsada con \$88,640.23 para el seguro medico HMO, bajo el programa de reaseguro de retirados este año, los \$88,640.23 serán utilizados aumentando la contribución para el seguro medico HMO de la ciudad por \$11.00 mensuales tanto para la cobertura de solteros, parejas, y familias. Con las nuevas tarifas bajo el Self-Funded Plan de la Ciudad, hay cambios en las tasas y algunas modificaciones de beneficios. Se adjunta las nuevas tarifas para cada uno de los programas. Los cambios a los beneficios bajo el Self-Funded Plan de COH son los siguientes: Un aumento en los co-pagos para visitas al consultorio medico, al especialista, a los servicios médicos de emergencia y deducibles nuevos para la atención de las recetas y en la red hospitalaria.

El periodo de inscripción comenzara el Lunes, Diciembre 4, 2012, hasta el Viernes, Diciembre 7, 2012 hasta las 4:00 P.M. Tenga en cuenta que el periodo para hacer cambios en los seguros terminara el viernes, Diciembre 7 del 2012 a las 4:00 P.M.

COH Self-funded Plan pagara los beneficios secundarios si usted es elegible para Medicare incluso si usted elige o no tener Medicare.

Bajo la COH Self-Funded Plan un individuo que califica para Medicare, nuestro Plan pagara como parte secundaria que Medicare. Esto se aplica para los jubilados que son elegibles para Medicare, ya sea que se este acercando a la edad de 65 años o si usted es deshabilitado i es elegible para los beneficios de Medicare. Esta condición se aplica a ustedes incluso si usted elige no elegir a Medicare. (Sin embargo, el Plan pagara los beneficios primero y Medicare paga segundo para personas con enfermedades renales en etapa final, por un periodo limitado de tiempo.) Por lo tanto, si usted es elegible para Medicare y opta por no inscribirse, el Plan de la Ciudad pagara los beneficios como si usted se ha inscrito bajo Medicare.

Elegibilidad para Dependientes.

La Ciudad ha sido aconsejada llevar a cabo una verificación de auditoria para los dependientes. Esto se hace con el fin de administrar los costos de atención medico general confirmado que solo sus dependientes elegibles están inscritos en los programas de seguro de salud de la Ciudad. Eliminando los dependientes inelegibles, ayuda a controlar los costos para todos los participantes del plan. Sin embargo, antes de realizar la verificación de auditoria de los dependientes, la Ciudad le gustaría actualizar sus registros. **La ciudad esta mirando para eliminar todo los dependientes que ya no son elegibles para los planes de la ciudad, es decir los cónyuges inelegibles a causa de divorcio o niños/a inelegibles debido a cambios en el estado de la custodia del hijo/a.** Actualmente no existe ninguna penalidad para eliminar dependientes inelegibles. Si algún dependiente inelegible permanece en los planes después de este periodo, la Ciudad requerirá el pago de cualquier reclamación pasado del seguro que los planes han incurrido en nombre de estos dependientes inelegibles. En caso de que haya una tergiversación intencional para aplicaciones de cobertura el jubilado será sujeto a la perdida de su propia cobertura de seguro.

Cualquier persona que desea hacer un cambio, lo deberá hacer durante la inscripción abierta, y debe permanecer dentro de ese plan hasta la próxima inscripción abierta programada por la Ciudad de Hialeah. Adjunto los beneficios de United Health Care Self-Funded Plan que ofrece la Ciudad. Si usted decide agregar o quitar dependiente del plan, puede hacerlo a través de la oficina de Risk Management ubicado en el tercer piso del ayuntamiento de la Ciudad. Todos los cambios se convertirán en efectivo el primero de Enero del 2013.

Si tiene alguna pregunta acerca de esta información, favor de llamar a la oficina de Risk Management al teléfono (305) 883-8050 o (305) 883-8048. Para obtener información de un representante de Coventry Health Plan favor de llamar al teléfono (888) 679-9140 entre las horas de 8:30 A.M. a 5:00 P.M. Si desea alguna información sobre el plan dental/visión usted puede hablar con un representante de Humana directamente al teléfono (800) 342-5209. Por favor visite la pagina del web-site de Risk Management al www.hialeahfl.gov para ver el resumen de plan de beneficios y las descripciones y otros actualizaciones con respecto a los diferentes programas de seguros de la ciudad. También, la inscripción abierta es una oportunidad para actualizar los formularios beneficiarios para los programas de seguro de vida de la ciudad en la oficina de Risk Management.

**INSURANCE PREMIUMS - RETIRED GENERAL, CONFIDENTIAL, SWORN POLICE,
AND SWORN FIREFIGHTER PERSONNEL CURRENTLY ENROLLED IN CITY OF
HIALEAH SELF-FUNDED PLAN OR COVENTRY HEALTHCARE**

Effective 1/1/2013

CITY OF HIALEAH - SELF FUNDED PLAN

Monthly
Premium

SINGLE \$ -0-
DOUBLE \$398.50
FAMILY \$869.84

COVENTRY HEALTH PLAN (HIGH OPTION):

Effective 1/1/2013

Monthly
Premium

SINGLE \$ -0-
DOUBLE \$374.88
FAMILY \$486.66

COVENTRY HEALTH PLAN (LOW OPTION):

Effective 1/1/2013

Monthly
Premium

SINGLE \$ -0-
DOUBLE \$326.78
FAMILY \$424.21

NOTE: Employer/Employee contributions for all plans and plan benefits are subject to change as a result of labor negotiations. Total monthly premium charged will be based on the nature of your retirement

***Monthly premiums are subject to increase depending on the nature of your retirement.*

DENTAL AND VISION 2013 RATES
EFFECTIVE 1/1/2013

Dental
Humana DHMO (CS150)

	Monthly Premium	Bi-Weekly Premium
SINGLE	\$14.44	\$6.66
DOUBLE	\$25.26	\$11.66
FAMILY	\$37.02	\$17.09

Humana PPO

	Monthly Premium	Bi-Weekly Premium
SINGLE	\$34.56	\$15.95
DOUBLE	\$67.38	\$31.10
FAMILY	\$120.04	\$55.40

Vision

Humana Visioncare

	Monthly Premium	Bi-Weekly Premium
SINGLE	\$6.62	\$3.06
DOUBLE	\$13.24	\$6.11
FAMILY	\$17.74	\$8.19

City of Hialeah General Employees

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee + Family Plan Type: PS1

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-866-873-3903.	
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Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$500 Individual / \$1,000 Family Non-Network: \$750 Individual / \$2,250 Family Does not apply to copays, prescription drugs, and services listed below as "No Charge". Per calendar year.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes, Prescription drugs – \$25 Individual.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Network: \$3,000 Individual Non-Network: \$6,000 Individual	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-notification for services, prescription drugs and copays.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Events chart describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.myuhc.com or call 1-866-873-3903 for a list of network providers.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services.

Questions: Call 1-866-873-3903 or visit us at www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary.**

If in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

City of Hialeah General Employees

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee + Family

Plan Type: PS1

- Co-payments (copays) are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

- Co-insurance (co-ins) is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your co-insurance payment of 20% would be \$200. This may change if you haven't met your deductible.

- The amount the plan pays for covered services is based on the allowed amount. If a non-network provider charges more than the allowed amount, you may have to pay the difference. For example, if a non-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Network Provider	Non-Network Provider	30% co-ins	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay per visit	30% co-ins		If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$50 copay per visit	30% co-ins		If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	10% co-ins per visit of Manipulative (Chiropractic) services	30% co-ins per visit of Manipulative (Chiropractic) services		Unlimited visits of Manipulative (Chiropractic) services per calendar year, limited to \$25,000. Pre-Notification is required non-network.
	Preventive care / screening / immunization	No Charge	30% co-ins		Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins	30% co-ins		Network deductible does not apply.
	Imaging (CT / PET scans, MRIs)	10% co-ins	30% co-ins		
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: \$10 copay Mail-Order: \$20 copay	Retail: \$10 copay Mail-Order: Not Covered		Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs,

City of Hialeah General Employees

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee + Family

Plan Type: PS1

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
More information about prescription drug coverage is available at www.myuhc.com	Tier 2 – Your Midrange-Cost Option	Retail: \$30 copay Mail-Order: \$60 copay	Retail: \$30 copay Mail-Order: Not Covered	including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost.
If you have outpatient surgery	Tier 3 – Your Highest-Cost Option	Retail: \$50 copay Mail-Order: \$100 copay	Retail: \$50 copay Mail-Order: Not Covered	If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
If you need immediate medical attention	Tier 4 – Additional High-Cost Option	Not Applicable	Not Applicable	See the website listed for information on drugs covered by your plan. Not all drugs are covered.
Emergency medical transportation	Facility fee (e.g., ambulatory surgery center)	10% co-ins	30% co-ins	None
	Physician / surgeon fees	10% co-ins	30% co-ins	None
	Emergency room services	\$250 copay per visit	\$250 copay per visit	Non-Network Pre-Service Notification is required if results in an Inpatient Stay.
	Urgent care	\$50 copay per visit	30% co-ins	Pre-service Notification is required for non-emergency ambulance.
	If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply. Non-Network Pre-Service Notification is required.
	If you have mental health,	Physician / surgeon fees	10% co-ins	None
	Mental / Behavioral health outpatient	\$25 copay per visit	30% co-ins	None

City of Hialeah General Employees

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee + Family Plan Type: PS1

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
behavioral health, or substance abuse needs	Services			
Mental / Behavioral health inpatient services	10% co-ins	30% co-ins		Pre-Notification is required non-network.
Substance use disorder outpatient services	\$25 copay per visit	30% co-ins		None
Substance use disorder inpatient services	10% co-ins	30% co-ins		Pre-Notification is required non-network.
If you become pregnant				
Prenatal and postnatal care	\$25 Global Maternity copay	30% co-ins		Additional copays, deductibles, or coins may apply. Routine pre-natal care is covered at No Charge.
Delivery and all inpatient services	10% co-ins	30% co-ins		Additional copays, deductible, coins may apply. Routine pre-natal care insurance or Notification may apply.
If you have a recovery or other special health needs				
Home health care	10% co-ins	30% co-ins		Limited to 60 days per calendar year. Pre-Notification is required non-network.
Rehabilitation services	10% co-ins	30% co-ins		Unlimited. Non-Network Pre-Notification required.
Habilitation services	Not Covered	Not Covered		No coverage for Habilitation services.
Skilled nursing care	10% co-ins	30% co-ins		Limited to 60 days per calendar year. Limit is combined with IP Rehabilitation Services. Pre-Notification is required non-network.
Durable medical equipment	10% co-ins	30% co-ins		Non-Network Pre-Notification is required for DME over \$1,000. Non-Network Pre-Notification is required.
Hospice service	10% co-ins	30% co-ins		No Coverage for Eye Exams.
If your child needs dental or eye care				No coverage for Glasses.
Eye exam	Not Covered	Not Covered		
Glasses	Not Covered	Not Covered		
Dental check-up	Not Covered	Not Covered		No coverage for Dental check-up.

City of Hialeah General Employees

Coverage Period: 01/01/2013 – 12/31/2013

Plan Type: PS1

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	<ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Cosmetic Surgery • Dental Care (Adult/Child) • Glasses • Hearing aids • Habilitation Services • Infertility Treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight Loss Programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	



City of Hialeah General Employees

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee + Family Plan Type: PS1

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit <http://www.cciio.cms.gov>.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://ccio.cms.gov/programs/consumer/capgrants/index.html>.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.

若需要中文协助，请拨打您会员卡上的电话号码

Dine Kehji shich'i haddodzhin ninizingo, bee neehozin biniyiye nanititingii number bikaal'igii bichi'i hodilinh

Para sa tulong sa Tagalog, tawagan ang numero sa iyong

----- To see examples of how this plan might cover costs for a sample medical situation, see the next page. -----

City of Hialeah General Employees

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Plan Type: PS1

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Questions and answers about Coverage Examples:

Having a baby (normal delivery)		Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
<input type="checkbox"/>	Amount owed to providers: \$7,540	<input type="checkbox"/>	Amount owed to providers: \$5,400
<input type="checkbox"/>	Plan Pays \$ 6,350	<input type="checkbox"/>	Plan Pays \$ 4,340
<input type="checkbox"/>	Patient Pays \$ 1,190	<input type="checkbox"/>	Patient Pays \$ 1,060
Sample care costs:		Sample care costs:	
Hospital charges (mother)	\$2,700	Prescriptions	\$2,900
Routine obstetric care	\$2,100	Medical Equipment and Supplies	\$1,300
Hospital charges (baby)	\$900	Office Visits and Procedures	\$700
Anesthesia	\$900	Education	\$300
Laboratory tests	\$500	Laboratory tests	\$100
Prescriptions	\$200	Vaccines, other preventive	\$100
Radiology	\$200	Total	\$5,400
Vaccines, other preventive	\$40		
Total	\$7,540		
Patient pays:		Patient pays:	
Deductibles	\$500	Deductibles	\$500
Co-pays	\$30	Co-pays	\$0
Co-insurance	\$510	Co-insurance	\$480
Limits or exclusions	\$150	Limits or exclusions	\$80
Total	\$1,190		
			\$1,060

City of Hialeah General Employees

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee + Family

Plan Type: PS1

What are some of the assumptions behind the Coverage Examples?	What does a Coverage Example show?	Can I use Coverage Examples to compare plans?
<ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher. • If other than individual coverage, the Patient Pays amount may be more. 	<p>For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p>✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides</p>
<p>Does the Coverage Example predict my own care needs?</p>	<p>✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p>✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
<p>Does the Coverage Example predict my future expenses?</p>	<p>✗ No. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.</p>	

Questions: Call 1-866-873-3903 or visit us at www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary.**

It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

Coventry Health Care of Florida: FDCOA 2060 \$3500
Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

Coverage Period: 01/01/2013 – 12/31/2013

A This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.chcflorida.com or by calling 1-866-847-8235.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: \$3,500 person / \$7,000 family. Applies to inpatient and outpatient hospital services. Out-of-network: Not Coveted	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$4,500 person / \$9,000 family Out-of-network: Not Covered	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket</u> limit?	Premiums and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.chcflorida.com or call 1-866-847-8235 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-866-847-8235 or visit us at www.chcflorida.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCOA 2060 \$3500

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles, copayments and coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Co-pay/visit	Not Covered	none
	Specialist visit	\$60 Co-pay/visit	Not Covered	none
	Other practitioner office visit	\$60 Co-pay/visit for spinal manipulation	Not Covered	Spinal manipulation is limited to 20 visits per calendar year.
If you have a test	Preventive care/screening/immunization	\$0	Not covered	none
	Diagnostic test (x-ray, blood work)	\$0 Co-pay/visit in physician office	Not Covered	none
	Imaging (CT/PET scans, MRIs)	\$75 co-pay/visit in Outpatient Diagnostic Center	Not Covered	Prior authorization is required for coverage.

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Coverage Period: 01/01/2013 – 12/31/2013

Coventry Health Care of Florida: FDCOA 2060 \$3500

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider		Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
		Generic drugs	\$20/\$20 Co-pay (retail/mail order)	Not Covered	
If you need drugs to treat your illness or condition.	Preferred brand drugs	\$45/\$90 Co-pay (retail/mail order)	Not Covered		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Preauthorization is required for some drugs.
More information about <u>prescription drug coverage</u> is available at www.chcflorida.com .	Non-preferred brand drugs	\$70/\$210 Co-pay (retail/mail order)	Not Covered		
If you have outpatient surgery	Specialty drugs	20% Co-insurance	Not Covered		\$250 out-of-pocket limit per month except for diabetic supplies.
If you need immediate medical attention	Facility fee (e.g., ambulatory surgery center)	\$300 co-pay/visit	Not Covered		—none—
	Physician/surgeon fees	\$0	Not Covered		—none—
	Emergency room services				Must meet emergency criteria. Co-payment waived if admitted.
	Emergency medical transportation	\$0	\$0		—none—
	Urgent care				—none—
If you have a hospital stay	Facility fee (e.g., hospital room)	\$60 Co-pay/visit	Not Covered		Prior authorization is required for coverage.
	Physician/surgeon fee	30% Co-insurance	Not Covered		—none—
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$60 Co-pay/visit	Not Covered		
	Mental/Behavioral health inpatient services	Deductible then 30% Co-insurance	Not Covered		
	Substance use disorder outpatient services	\$60 Co-pay/visit	Not Covered		Prior authorization is required for coverage.
	Substance use disorder inpatient services	Deductible then 30% Co-insurance	Not Covered		
If you are pregnant	Prenatal and postnatal care	\$60 Co-pay	Not Covered		Applies to the first visit only.

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Coventry Health Care of Florida: FDCOA 2060 \$3500
Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

Coverage Period: 01/01/2013 – 12/31/2013

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Delivery and all inpatient services	Deductible then 30% Co-insurance	Not Covered	Premarkit is required for coverage.
	Home health care	\$0	Not Covered	Premarkit is required for coverage. Limited to 60 visits/year.
	Rehabilitation services	Inpatient: Deductible then 30% Co-insurance; Outpatient: \$60 Co-pay/visit	Not Covered	Premarkit is required for inpatient coverage. Coverage is limited to 30 inpatient days and 60 visits/year, combined for all therapies.
	Habilitation services	Not Covered	Not Covered	Excluded Service
	Skilled nursing care	\$100 Co-pay/day for the first 5 days	Not Covered	Premarkit is required for coverage. Limited to 30 days/year.
	Durable medical equipment	\$50 Co-pay	Not Covered	Premarkit is required for coverage.
	Hospice service	\$0	Not Covered	Premarkit is required for coverage. Limited to 210 days/lifetime.
	Eye exam	\$0	Not Covered	Limited to routine screenings in the PCP office.
	If your child needs dental or eye care	Glasses \$29 Co-pay single vision frames	Not Covered	Coverage is limited to one pair of glasses per year.
	Dental check-up	\$0	Not Covered	Coverage is limited to one cleaning every 6 months.

Questions: Call 1-866-847-8235 or visit us at www.cheflorida.com.
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Coventry Health Care of Florida: FDCOA 2060 \$3500
Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

Coverage Period: 01/01/2013 – 12/31/2013

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Cosmetic surgery
- Long-term care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Routine eye care (adult)
- Dental care (adult)
- Routine foot care (if prescribed for diabetics)

Questions: Call 1-866-847-8235 or visit us at www.chcfloridacom.
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at www.cciio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCOA 2060 \$3500

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

Coverage Period: 01/01/2013 – 12/31/2013

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-866-847-8235**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

For group health coverage subject to ERISA, you may contact **1-866-847-8235**. You may also contact, the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform, or your state department of insurance at Florida Department of Financial Services Division of Consumer Services, 200 E. Gaines St., Tallahassee, FL, 32399-0322, **1-877-693-5236**. www.myfloridacfo.com/Division/Consumers/NeedOurHelp.htm.

For non-federal governmental group health plans and church plans that are group health plans, you may contact **1-866-847-8235** or your state department of insurance at Florida Department of Financial Services Division of Consumer Services, 200 E. Gaines St., Tallahassee, FL, 32399-0322, **1-877-693-5236**. www.myfloridacfo.com/Division/Consumers/NeedOurHelp.htm.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-866-847-8235.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-847-8235.
- Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-847-8235.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-847-8235.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

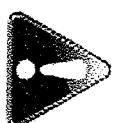
Questions: Call **1-866-847-8235** or visit us at www.chcflorida.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCA 2060 \$3500

Coverage Period: 01/01/2013 – 12/31/2013
Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$3,441
- **Patient pays:** \$4,099

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$3,123
- **Patient pays:** \$2,277

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$3,500
Copays	\$158
Ccoinsurance	\$291
Limits or exclusions	\$150
Total	\$4,099

Questions: Call 1-866-847-8235 or visit us at www.chcflorida.com.
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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

X No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

X No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Questions: Call 1-866-847-8235 or visit us at www.chcflorida.com.
If you aren't clear about any of the undefined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCOA2060 \$3500

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios

Cobertura de: EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

! Éste es solo un resumen. Si desea más información sobre la cobertura y los precios, puede obtener los documentos del plan o términos de la póliza en www.chcflorida.com o llamando al 1-866-847-8235

Preguntas importantes	Respuestas	¿Por qué es importante?
¿Qué es el deducible general ?	Proveedores participantes: \$3,500 individual / \$7,000 familia Se aplica a los servicios hospitalarios y ambulatorios de hospitales. Proveedores non-participantes: No cubierto	Usted paga todos los costos hasta llegar al monto del deducible antes de que el plan comience a pagar los servicios cubiertos que reciba. Revise su póliza o documento del plan y vea cuándo comienza de nuevo el deducible (generalmente, no siempre, el 1 de enero). Vea en la tabla (página 2) cuánto paga por servicios cubiertos después de pagar el deducible .
¿Hay otros deducibles para servicios específicos ?	No.	No tiene que pagar deducibles por servicios específicos, pero vea en la tabla que comienza en la página 2 otros costos de servicios cubiertos por este plan.
¿Hay un límite para los gastos de mi bolsillo ?	Sí. Proveedores participantes: \$4,500 individual / \$9,000 familia Proveedores non-participantes: No cubierto	El límite de gastos del bolsillo es lo máximo que usted pagaría en un período de cobertura (generalmente un año) por la parte del gasto que le corresponde a usted por los servicios cubiertos. Este límite le ayuda a planificar sus gastos médicos.
¿Cuáles son las expensas que no cuentan para el límite de gastos del bolsillo ?	Las primas y atención médica que este plan no cubre.	Aunque usted pague estos costos, ellos no cuentan para su límite de gastos del bolsillo .
¿Hay un límite anual general para lo que paga el plan?	No.	La tabla de la página 2 describe los límites sobre los que el plan pagará los servicios cubiertos <i>específicos</i> , tales como las visitas al consultorio.
¿Tiene este plan una red de proveedores?	Sí. Vea www.chcflorida.com o llame al 1-866-847-8235 para una lista de proveedores participantes.	Si va a un médico o proveedor de atención médica dentro de la red, el plan paga algunos o todos los costos de servicios cubiertos. Tenga en cuenta que su médico u hospital de la red puede usar un proveedor fuera de la red para algunos servicios. Los planes usan el término dentro de la red, preferido o participante para los proveedores incluidos en su red . Vea la tabla de la página 2 para saber cómo el plan paga a los diferentes tipos de proveedores .

Preguntas: Llame al 1-866-847-8235 o visite www.chcflorida.com. Si no entiende alguno de los términos en negritas, consulte el Glosario en www.cciio.cms.gov o llame al 1-866-847-8235 y pida una copia.

Coventry Health Care of Florida: FDCOA2060 \$3500

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

• ¿Necesito un referido para ver un especialista?	No.	Puede ver al especialista que seleccione sin necesidad de un permiso del plan.
• ¿Hay algún servicio(s) que el plan no cubra?	Sí.	Algunos servicios no cubiertos por el plan aparecen en la página 4. Vea su póliza o documento del plan para más información sobre los servicios excluidos .

Número de control OMB 1545-2229
1210-0147 y 0938-1146
Corrected on May 11, 2012

- A** • **Copago** es una cantidad fija (por ejemplo \$15) que usted paga por los servicios médicos cubiertos, generalmente al momento de recibirlos. **Coseguro** es la parte que le corresponde pagar a *usted* por un servicio cubierto, que es un porcentaje de la **cantidad aprobada** para dicho servicio. Por ejemplo, si la **cantidad aprobada** por el plan para pasar la noche en el hospital es \$1,000, su coseguro será el 20% de esa cantidad o sea \$200. Esta cantidad puede cambiar si usted aún no ha pagado el **deductible**.
- El pago del plan por los servicios cubiertos está basado en la **cantidad aprobada**. Si un **proveedor** fuera de la red (que no pertenece a la red del plan) le cobra más de la **cantidad aprobada**, usted tendrá que pagar la diferencia. Por ejemplo, en un hospital que no pertenece a la red le cobran por pasar la noche internado \$1,500 la **cantidad aprobada** es \$1,000, usted tendrá que pagar la diferencia de \$500 (conocida como **saldo de facturación**).
 - El plan puede animarlo a que use **proveedores** _____ cobrándole **deductibles, copagos o coseguro** más bajos.

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si se atiende en la clínica o consultorio del proveedor médico	Consulta con su médico principal para tratar una condición o herida	\$20 de copago / visita	No cubierto _____—ninguna—_____	
	Consulta con un especialista	\$60 de copago / visita	No cubierto _____—ninguna—_____	
	Consulta con otro proveedor de la salud	\$60 de copago / visita (atención quirúpráctica)	No cubierto _____—ninguna—_____	Cobertura limitada a 20 visitas / año.
Si tiene que hacerse un examen	Exámenes de diagnóstico (radiografías, análisis de sangre)	\$0	No cubierto _____—ninguna—_____	
	Imágenes (CT/PET scan, MRI)	\$75 de copago / visita al centro diagnóstico ambulatorio	No cubierto _____—ninguna—_____	Necesita autorización previa para cobertura.

Preguntas: Llame al 1-866-847-8235 o visite www.chcflorida.com. Si no entiende alguno de los términos en negritas, consulte el Glosario en www.ccio.cms.gov o llame al 1-866-847-8235 y pida una copia.

Coventry Health Care of Florida: FDCOA2060 \$3500

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios

Cobertura de: EE, EECónyuge, EEPijo(s), EE/Familia | **Tipo de plan:** HMO

Duración de la póliza: 01/01/2013 – 12/31/2013

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita un medicamento	Medicamentos genéricos	\$20 de copago (minorista); \$20 de copago (pedido por correo)	No cubierto	
Para más información sobre la cobertura de medicamentos visite www.chcfiorida.com .	Medicamentos de marca preferidos	\$45 de copago (minorista); \$90 de copago (pedido por correo)	No cubierto	Cubre hasta un suministro de 30-días (minorista) y un suministro de 90 días (pedido por correo). Necesita autorización previa para algunos medicamentos.
	Medicamentos de marca no preferidos	\$70 de copago (minorista); \$210 de copago (pedido por correo)	No cubierto	
	Medicamentos especiales	20% de coseguro	No cubierto	\$250 de límite de gastos del bolsillo mensual excepto en suministros para diabéticos.
Si le hacen una cirugía ambulatoria	Arancel del centro (clínica)	\$300 de copago / visita	No cubierto	— ninguna —
	Tarifa del médico / cirujano	\$0	No cubierto	— ninguna —

Preguntas: Llame al 1-866-847-8235 o visite www.chcfiorida.com.

Si no entiende alguno de los términos en negritas, consulte el Glosario en www.cciio.cms.gov o llame al 1-866-847-8235 y pida una copia.

Coventry Health Care of Florida: FDCOA2060 \$3500

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita atención inmediata	Servicios de la sala de emergencias Traslado médico de emergencia Cuidado urgente	\$300 de copago / visita \$0 \$0	\$300 de copago / visita \$0 No cubierto	Debe cumplir criterios de emergencia. Sin copago si lo ingresan. ————— ninguna —————
Si lo admiten al hospital	Arancel del hospital (habitación) Tarifa del médico/cirujano Servicios ambulatorios de salud mental y de la conducta Servicios de salud mental y de la conducta para pacientes internados Tratamiento ambulatorio para el abuso de sustancias Tratamiento para el abuso de sustancias para pacientes internados Cuidados prenatales y post parto Si está embarazada	Deducible y luego 30% de coseguro Deducible y luego 30% de coseguro \$60 de copago / visita \$60 de copago / visita \$60 de copago / visita \$60 de copago \$60 de copago Deducible y luego 30% de coseguro	No cubierto No cubierto No cubierto No cubierto No cubierto No cubierto No cubierto No cubierto	Necesita autorización previa para cobertura. ————— ninguna —————
Si tiene problemas psiquiátricos, de conducta o de abuso de sustancias	Servicios de salud mental y de la conducta para pacientes internados Tratamiento ambulatorio para el abuso de sustancias Tratamiento para el abuso de sustancias para pacientes internados Cuidados prenatales y post parto Parto y todos los servicios de internación	Deducible y luego 30% de coseguro \$60 de copago / visita \$60 de copago Deducible y luego 30% de coseguro	No cubierto No cubierto No cubierto No cubierto No cubierto	Necesita autorización previa para cobertura. Corresponde solo a la primera visita. Necesita autorización previa para cobertura.

Preguntas: Llame al 1-866-847-8235 o visite www.chcfloida.com.
 Si no entiende alguno de los términos en negritas, consulte el Glossario en www.cciio.cms.gov o llame al 1-866-847-8235 y pida una copia.

Coventry Health Care of Florida: FDCOA2060 \$3500

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios Cobertura de: EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | Tipo de plan: HMO

Duración de la póliza: 01/01/2013 – 12/31/2013

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Cuidado de la salud en el hogar	\$0	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 60 visitas/año.	
Servicios de rehabilitación	Pacientes internados: Deducible y luego 30% de coseguro Servicios de consulta externa: \$60 de copago / visita	No cubierto No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 60 visitas/año.	
Servicios de recuperación de las habilidades	\$100 de copago/días, 1-5 días	No cubierto	Servicio excluido	Necesita autorización previa para cobertura. Cobertura limitada a 30 días/año.
Equipo médico duradero	\$50 de copago	No cubierto	Necesita autorización previa para cobertura.	Necesita autorización previa para cobertura. Cobertura limitada a 210 días/de por vida.
Cuidado de hospicio	\$0	No cubierto	Límitado al pruebas de detección de rutina en el consultorio del PCP.	Límitado al pruebas de detección de rutina en el consultorio del PCP.
Si su hijo necesita servicios dentales o servicios de la vista	\$29 de copago por marcos monofocales	No cubierto	Cobertura limitada a un par de anteojos anual.	Cobertura limitada a una limpieza cada 6 meses.
Anteojos	\$0	No cubierto		
Consulta dental	\$0	No cubierto		

Preguntas: Llame al 1-866-847-8235 o visite www.chcflorida.com. Si no entiende alguno de los términos en negritas, consulte el Glosario en www.ccio.cms.gov o llame al 1-866-847-8235 y pida una copia.

Coventry Health Care of Florida: FDCOA2060 \$3500

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios

Cobertura de: EE, EECónyuge, EE/Hijo(s), EE/Familia | Tipo de plan: HMO

Servicios excluidos y otros servicios cubiertos:

Los servicios que su plan NO cubre. (Esta es una lista parcial. Consulte los documentos del plan para más información.)

- Acupuntura
- Cirugía bariátrica
- Cirugía estética
- Aparatos auditivos
- Tratamiento de infertilidad
- Cuidados prolongados
- Atención que no sea de emergencia al viajar fuera de EE.UU.
- Atención de enfermería privada
- Programas para bajar de peso

Otros servicios cubiertos. (Esta es una lista parcial. Consulte los documentos del plan para otros servicios cubiertos y sus precios.)

- Atención de quiropráctico
- Atención dental (Adulto)
- Atención rutinaria de la vista (Adulto)
- Atención rutinaria del pie (si se receta a diabéticos)

Su derecho para continuar con la cobertura:

Si pierde la cobertura bajo el plan, dependiendo de las circunstancias, las leyes federales y estatales pueden brindarle protecciones que le permiten tener cobertura de salud. Tales derechos pueden ser limitados en duración y se le exigirá que usted pague una **prima**, que puede ser significativamente mayor que la prima que paga al estar cubierto por el plan. También puede aplicar otras limitaciones en sus derechos para continuar la cobertura.

Para más información sobre sus derechos para continuar la cobertura, comuníquese con el plan al **1-866-847-8235**. También puede llamar al departamento de seguros de su estado, al Departamento del Trabajo de EE.UU., a la Administración para la Seguridad de los Beneficios del Trabajador al 1-866-444-3272 o www.dol.gov/ebsa, o al Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-267-2323 ext.61565 o www.ccio.cms.gov.

Su derecho a presentar una queja o una apelación:

Si tiene una queja o no está satisfecho con una negación de cobertura por reclamaciones hechas bajo su plan, puede **apelar** o presentar una **queja formal**. Para preguntar sobre sus derechos, este aviso o solicitar ayuda, puede llamar al plan al **1-866-847-8235**. También puede llamar al departamento de seguros de su estado, al Departamento del Trabajo de EE.UU., a la Administración para la Seguridad de los Beneficios del Trabajador al 1-866-444-3272 o www.dol.gov/ebsa/healthreform, o al Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-267-2323 ext.61565 o www.ccio.cms.gov.

Servicios de acceso a idiomas:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-847-8235.
Tagalog (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-866-847-8235.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-847-8235.
Navajo (Dine): Dinek'ehgo shika at'ohwol nisingo, kwijigo holne' 1-866-847-8235.

Para ejemplos sobre cómo este plan paga por los servicios en una situación médica específica consulte la página siguiente:

Preguntas: Llame al **1-866-847-8235** o visite www.chkflorida.com.

Si no entiende alguno de los términos en negritas, consulte el Glosario en www.ccio.cms.gov o llame al **1-866-847-8235** y pida una copia.

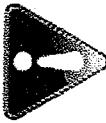
Duración de la póliza: 01/01/2013 – 12/31/2013

Coventry Health Care of Florida: FDCOA2060 \$3500

Duración de la póliza: 01/01/2013 – 12/31/2013
Cobertura de: EE, EE/Sposse, EE/Child(ren), EE/Family | Tipo de plan: HMO

Sobre los ejemplos de cobertura:

Estos ejemplos le muestran cómo cubriría el plan los servicios en situaciones distintas. Úselos para tener una idea de cuánta cobertura económica podría obtener el paciente del ejemplo de los distintos planes.



Ésta no es una herramienta de cálculo de costos

No use estos ejemplos para calcular los costos reales de su plan. Los servicios médicos que usted reciba y los precios pueden ser distintos a los mencionados en los ejemplos.

Para información importante sobre estos ejemplos, consulte la página siguiente.

Nacimiento (parto normal)

- El proveedor cobra: \$7,540
- El plan paga: \$3,441
- Usted paga: \$4,099

Ejemplos de los costos:

El costo del hospital (madre)	\$2,700
Atención de rutina del obstetra	\$2,100
El costo del hospital (bebé)	\$900
Anestesia	\$900
Analisis de laboratorio	\$500
Medicamentos	\$200
Radiografías	\$200
Vacunas y otros servicios preventivos	\$40
Total	\$7,540

Control de la diabetes (control nutriente de la enfermedad)

- El proveedor cobra: \$5,400
- El plan paga: \$3,123
- Usted paga: \$2,277

Ejemplo de los costos:

Medicamentos	\$2,900
Equipo médico e insumos	\$1,300
Visitas al consultorios y procedimientos médicos	\$700
Educación sobre el cuidado	\$300
Analisis de laboratorio	\$100
Vacunas y otros servicios preventivos	\$100
Total	\$5,400

El paciente paga:

Deductibles	\$0
Copagos	\$2,238
Coseguro	\$0
Límites o exclusiones	\$39
Total	\$2,277

Preguntas y respuestas sobre los ejemplos mencionados:

¿Qué conceptos se presuponen de estos ejemplos?

- Los costos no incluyen las **primas**.
- Los ejemplos de costos están basados en los promedios nacionales provenientes del Departamento de Salud y Servicios Humanos de los EE.UU. y que no son específicos para una zona geográfica o un plan.
- La afección del paciente no es una condición excluida ni preexistente.
- Todos los servicios y tratamientos empezaron y terminaron en el mismo período de cobertura.
- No hay otros gastos médicos para ningún miembro cubierto por este plan.
- Los gastos del bolsillo están basados solamente en el tratamiento del problema mencionado en el ejemplo.
- El paciente recibió todos los servicios de **proveedores** de la red del plan. Si el paciente hubiese recibido los servicios de **proveedores** fuera de la red, los costos hubieran sido más altos.
- Los costos reales dependen de los servicios que reciba, del precio del **proveedor** y del reembolso que autorice el plan.

¿Qué muestra el ejemplo?

En cada ejemplo verá cómo suman los **deductibles**, **copagos** y **coseguro**. También le ayudan a ver cuáles son los gastos que tendrá que pagar usted porque no están cubiertos o porque el pago es limitado.

¿Contempla el ejemplo mis propias necesidades?

✗ **No.** Los tratamientos que mencionamos son solo ejemplos. El tratamiento que usted podría recibir para esta condición tal vez sea distinto, según cuál sea el consejo de su médico, su edad, la gravedad de su caso y otros factores.

¿Puede el ejemplo predecir mis gastos futuros?

✗ **No.** Los ejemplos de cobertura no son herramientas de cálculo de costos. Usted no puede usar el ejemplo para estimar el costo del cuidado de su condición. El ejemplo es únicamente para fines comparativos. Sus costos reales dependerán de los servicios que reciba, del precio del **proveedor** y del reembolso que autorice el plan.

¿Puedo usar los ejemplos para comparar los planes?

✓ **Sí.** Cuando usted se fija en el Resumen de Beneficios y Cobertura de otros planes, encontrará los mismos ejemplos de cobertura. Cuando compare los planes, fíjese en el casillero titulado “Usted paga” de cada ejemplo. Cuanto más bajo el número, mayor será la cobertura ofrecida por el plan.

¿Debo tener en cuenta otros costos al comparar los planes?

✓ **Sí.** Un gasto importante es lo que paga de **prima**. Por lo general, cuanto más baja sea la prima mayores serán los gastos de su bolsillo, como los **copagos**, **deductibles** y **coseguro**. También debe tener en cuenta las contribuciones a cuentas tales como las Cuentas de Ahorros Médicos (HSA), Acuerdos de Gastos Flexibles (FSA) o las Cuentas de Reembolsos Médicos (HRA) que le ayudan con los gastos del bolsillo.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.chcflorida.com or by calling 1-866-847-8235.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: \$5,000 per person Applies to inpatient and outpatient hospital services. Out-of-network: Not Covered	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$10,000 person / \$20,000 family Out-of-network: Not Covered	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket</u> limit?	Premiums and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <u>specific</u> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.chcflorida.com or call 1-866-847-8235 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, <u>preferred</u> , or participating for providers in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-866-847-8235 or visit us at www.chcflorida.com.
 If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 Co-pay/visit	Not Covered	none
	Specialist visit	\$80 Co-pay/visit	Not Covered	none
	Other practitioner office visit for spinal manipulation	\$80 Co-pay/visit	Not Covered	Spinal manipulation is limited to 20 visits per calendar year.
If you have a test	Preventive care/screening/immunization	\$0	Not covered	none
	Diagnostic test (x-ray, blood work)	\$0 Co-pay/visit in physician office	Not Covered	none
	Imaging (CT/PET scans, MRIs)	\$80 co-pay/visit in Outpatient Diagnostic Center	Not Covered	Prior authorization is required for coverage.

Questions: Call **1-866-847-8235** or visit us at www.chcflorida.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **1-866-847-8235** to request a copy.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

Coverage Period: 01/01/2013 – 12/31/2013

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	\$10/\$10 Co-pay (retail/mail order)	Not Covered	Includes \$3 Co-pay/\$3 Co-Pay prescription (Retail/Mail Order) for select generic drugs. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Preauthorization is required for some drugs.
More information about <u>prescription drug coverage</u> is available at www.chcflorida.com .	Preferred brand drugs	\$45/\$90 Co-Pay (retail/mail order)	Not Covered	
If you have outpatient surgery	Non-preferred brand drugs	\$70/\$210 Co-Pay (retail/mail order)	Not Covered	
If you have immediate medical attention	Specialty drugs	20% Co-insurance	Not Covered	\$250 out-of-pocket limit per month except for diabetic supplies.
If you need immediate medical attention	Facility fee (e.g., ambulatory surgery center)	\$250 co-pay/visit	Not Covered	—————none—————
If you have a hospital stay	Physician/ surgeon fees	\$0	Not Covered	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Emergency room services	\$300 co-pay/visit	\$300 co-pay/visit	Must meet emergency criteria. Co-payment waived if admitted.
If you have a hospital stay	Emergency medical transportation	\$0	\$0	—————none—————
If you have a hospital stay	Urgent care	\$0	Not Covered	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$50 Co-pay/visit	Not Covered	Preauthorization is required for coverage.
If you have a hospital stay	Physician/surgeon fee	Deductible then 40% Co-insurance	Not Covered	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$80 Co-pay/visit	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	Deductible then 40% Co-insurance	Not Covered	
If you are pregnant	Substance use disorder outpatient services	\$80 Co-pay/visit	Not Covered	Premarkitization is required for coverage.
If you are pregnant	Substance use disorder inpatient services	Deductible then 40% Co-insurance	Not Covered	
If you are pregnant	Prenatal and Postnatal care	\$80 Co-pay	Not Covered	Applies to the first visit only.

Questions: Call 1-866-847-8235 or visit us at www.chcflorida.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
Delivery and all inpatient services	Deductible then 40% Co-insurance	Not Covered	Preauthorization is required for coverage.	
Home health care	\$0	Not Covered	Preauthorization is required for coverage. Limited to 60 visits/year.	
Rehabilitation services	Inpatient: Deductible then 40% Co-insurance; Outpatient: \$80 Co-pay/visit	Not Covered	Preauthorization is required for inpatient coverage. Coverage is limited to 30 inpatient days and 60 visits/year, combined for all therapies.	
Habilitation services	Not Covered	Excluded Service		
Skilled nursing care	\$100 Co-pay/day For the first 5 days	Not Covered	Preauthorization is required for coverage. Limited to 30 days/year.	
Durable medical equipment	\$0	Not Covered	Preauthorization is required for coverage.	
Hospice service	\$0	Not Covered	Preauthorization is required for coverage. Limited to 210 days/lifetime.	
Eye exam	\$0	Not Covered	Limited to routine screenings in the PCP office.	
If your child needs dental or eye care	Glasses vision frames	\$29 Co-pay single Not Covered	Coverage is limited to one pair of glasses per year.	
Dental check-up	\$0	Not Covered	Coverage is limited to one cleaning every 6 months.	

Questions: Call 1-866-847-8235 or visit us at www.chcfloida.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Dental care (adult)
- Routine eye care (adult)
- Routine foot care (if prescribed for diabetics)

Questions: Call 1-866-847-8235 or visit us at www.chcflorida.com.

If you aren't clear about any of the undefined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-866-847-8235**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.hrsa.hhs.gov.

Your Grievance and Appeals Rights:

For group health coverage subject to ERISA, you may contact **1-866-847-8235**. You may also contact, the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform, or your state department of insurance at Florida Department of Financial Services Division of Consumer Services, 200 E. Gaines St., Tallahassee, FL, 32399-0322, **1-877-693-5236**. www.myfloridaco.com/Division/Consumers/NeedOurHelp.htm.

For non-federal governmental group health plans and church plans that are group health plans, you may contact **1-866-847-8235** or your state department of insurance at Florida Department of Financial Services Division of Consumer Services, 200 E. Gaines St., Tallahassee, FL, 32399-0322, **1-877-693-5236**. www.myfloridaco.com/Division/Consumers/NeedOurHelp.htm.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-847-8235.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-847-8235.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-847-8235.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-847-8235.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call **1-866-847-8235 or visit us at www.chf florida.com.**

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **1-866-847-8235** to request a copy.

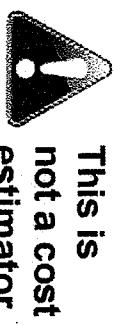
Coventry Health Care of Florida: FDCOAX4-40 \$5000

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

Coverage Period: 01/01/2013 – 12/31/2013

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$2,743
- **Patient pays** \$4,797

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Managing type 2 diabetes (routine maintenance of a well controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,454
- **Patient pays** \$1,946

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Deductibles	\$0
Copays	\$1,907
Coinsurance	\$0
Limits or exclusions	\$39
Total	\$1,946

Questions: Call 1-866-847-8235 or visit us at www.chcflorida.com. If you aren't clear about any of the undefined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-847-8235 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Does the Coverage Example predict my own care needs?

* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Does the Coverage Example predict my future expenses?

* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Questions: Call 1-866-847-8235 or visit us at www.chcflorida.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-847-8235 to request a copy.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios Cobertura de: EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | Tipo de plan: HMO

! Éste es solo un resumen. Si desea más información sobre la cobertura y los precios, puede obtener los documentos del plan o términos de la póliza en www.chcflorida.com o llame al 1-866-847-8235

Preguntas importantes	Respuestas	¿Por qué es importante?
¿Qué es el <u>deductible</u> general?	Proveedores participantes: \$5,000 individual Se aplica a los servicios hospitalarios y ambulatorios de hospitales. Proveedores non-participantes: No cubierto	Usted paga todos los costos hasta llegar al monto del deductible antes de que el plan comience a pagar los servicios cubiertos que reciba. Revise su póliza o documento del plan y vea cuándo comienza de nuevo el deductible (generalmente, no siempre, el 1 de enero). Vea en la tabla (página 2) cuánto paga por servicios cubiertos después de pagar el deductible .
¿Hay otros <u>deductibles</u> para servicios específicos?	No.	No tiene que pagar deductibles por servicios específicos, pero vea en la tabla que comienza en la página 2 otros costos de servicios cubiertos por este plan.
¿Hay un límite para los gastos de mi bolsillo?	Sí. Proveedores participantes: \$10,000 individual / \$20,000 familia Proveedores non-participantes: No cubierto	El límite de gastos del bolsillo es lo máximo que usted pagaría en un período de cobertura (generalmente un año) por la parte del gasto que le corresponde a usted por los servicios cubiertos. Este límite le ayuda a planificar sus gastos médicos.
¿Cuáles son las expensas que no cuentan para el límite de gastos del bolsillo?	Los primas y atención médica que este plan no cubre.	Aunque usted pague estos costos, ellos no cuentan para su límite de gastos del bolsillo .
¿Hay un <u>límite anual</u> general para lo que paga el plan?	No.	La tabla de la Página 2 describe los límites sobre los que el plan pagará los servicios cubiertos <i>específicos</i> , tales como las visitas al consultorio.
¿Tiene este plan una <u>red de proveedores</u> ?	Sí. Vea www.chcflorida.com o llame al 1-866-847-8235 para una lista de proveedores participantes.	Si va a un médico o proveedor de atención médica dentro de la red, el plan paga algunos o todos los costos de servicios cubiertos. Tenga en cuenta que su médico u hospital de la red puede usar un proveedor fuera de la red para algunos servicios. Los planes usan el término dentro de la red, preferido o participante para los proveedores incluidos en su red. Vea la tabla de la página 2 para saber cómo el plan paga a los diferentes tipos de proveedores .
¿Necesito un referido	No.	Puede ver al especialista que seleccione sin necesidad de un permiso del plan.

Preguntas: Llame al 1-866-847-8235 o visite www.chcflorida.com. Si no entiende alguno de los términos en negritas, consulte el Glosario en www.cciio.cms.gov o llame al 1-866-847-8235 y pida una copia.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

para ver un especialista?		Algunos servicios no cubiertos por el plan aparecen en la página 4. Vea su póliza o documento del plan para más información sobre los servicios excluidos .
¿Hay algún servicio(s) que el plan no cubra?	Sí.	



- **Copago** es una cantidad fija (por ejemplo \$15) que usted paga por los servicios médicos cubiertos, generalmente al momento de recibirlos.
- **Coseguro** es la parte que le corresponde pagar *a usted* por un servicio cubierto, que es un porcentaje de la **cantidad aprobada** para dicho servicio. Por ejemplo, si la **cantidad aprobada** por el plan para pasar la noche en el hospital es \$1,000, su coseguro será el 20% de esa cantidad o sea \$200. Esta cantidad puede cambiar si usted aún no ha pagado el **deducible**.
- El pago del plan por los servicios cubiertos está basado en la **cantidad aprobada**. Si un **proveedor** fuera de la red (que no pertenece a la red del plan) le cobra más de la **cantidad aprobada**, usted tendrá que pagar la diferencia. Por ejemplo, en un hospital que no pertenece a la red le cobran por pasar la noche internado \$1,500 la **cantidad aprobada** es \$1,000, usted tendrá que pagar la diferencia de \$500 (conocida como **saldo de facturación**.)
- El plan puede animarlo a que use **proveedores** _____ cobrándole **deductibles, copagos o coseguro** más bajos.

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si se atiende en la clínica o consultorio del proveedor médico	Consulta con su médico principal para tratar una condición o herida	\$10 de copago / visita	No cubierto	_____ninguna_____
	Consulta con un especialista	\$80 de copago / visita	No cubierto	_____ninguna_____
	Consulta con otro proveedor de la salud	\$80 de copago / visita (atención quirúpráctica)	No cubierto	Cobertura limitada a 20 visitas/año.
Si tiene que hacerse un examen	Servicios preventivos / evaluaciones / vacunas	\$0	No cubierto	_____ninguna_____
	Exámenes de diagnóstico (radiografías, análisis de sangre)	\$0 de copago / visita al consultorio del médico	No cubierto	_____ninguna_____
	Imágenes (CT/PET scan, MRI)	\$80 de copago / visita al centro diagnóstico ambulatorio	No cubierto	Necesita autorización previa para cobertura.

Número de control OMB 1545-2229
1210-0147 y 0938-1146
Corrected on May 11, 2012

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EECónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita un medicamento Para más información sobre la cobertura de medicamentos visite www.chcflorida.com .	Medicamentos genéricos Medicamentos de marca preferidos	\$10 de copago (minorista); \$10 de copago (pedido por correo) \$45 de copago (minorista); \$90 de copago (pedido por correo)	No cubierto No cubierto	Incluye receta \$3 copago por medicamentos genéricos selectos. Cubre hasta un suministro de 30-días (minorista) y un suministro de 90 días (pedido por correo). Necesita autorización previa para algunos medicamentos.
	Medicamentos de marca no preferidos	\$70 de copago (minorista); \$210 de copago (pedido por correo)	No cubierto	\$250 de límite de gastos del bolsillo mensual excepto en suministros para diabéticos.
Si le hacen una cirugía ambulatoria	Arancel del centro (clínica)	\$250 de copago / visita	No cubierto	ninguna
	Tarifa del médico / cirujano	\$0	No cubierto	ninguna

Preguntas: Llame al 1-866-847-8235 o visite www.chcflorida.com.

Si no entiende alguno de los términos en negritas, consulte el Glosario en www.cciio.cms.gov o llame al 1-866-847-8235 y pida una copia. **3 de 8 - Spanish**

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EI/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Duración de la póliza: 01/01/2013 – 12/31/2013

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita atención inmediata				
Servicios de la sala de emergencias	\$300 de copago/visita	\$300 de copago/visita	Debe cumplir criterios de emergencia. Sin copago si lo ingresan.	ninguna
Traslado médico de emergencia	\$0	\$0	No cubierto	Necesita autorización previa para cobertura.
Cuidado urgente				ninguna
Si lo admiten al hospital				
Arancel del hospital (habitación)	Deductible y luego 40% de coseguro	No cubierto		
Tarifa del médico/cirujano	Deductible y luego 40% de coseguro	No cubierto		
Servicios ambulatorios de salud mental y de la conducta	\$80 de copago/visita	No cubierto		
Servicios de salud mental y de la conducta para pacientes internados	Deductible y luego 40% de coseguro	No cubierto		
Tratamiento ambulatorio para el abuso de sustancias	\$80 de copago/visita	No cubierto		Necesita autorización previa para cobertura.
Tratamiento para el abuso de sustancias para pacientes internados	Deductible y luego 40% de coseguro	No cubierto		
Si está embarazada				
Cuidados prenatales y post parto	\$80 de copago	No cubierto		Corresponde solo a la primera visita.
Parto y todos los servicios de internación	Deductible y luego 40% de coseguro	No cubierto		Necesita autorización previa para cobertura.

Preguntas: Llame al 1-866-847-8235 o visite www.chcfloida.com.
Si no entiende alguno de los términos en negritas, consulte el Glosario en www.cciio.cms.gov o llame al 1-866-847-8235 y pida una copia.

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EECónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Cuidado de la salud en el hogar	\$0	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 60 visitas/año.	
Servicios de rehabilitación	Pacientes internados: Deducible y luego 40% de coseguro Servicios de consulta externa: \$80 de copago/visita	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 60 visitas/año.	
Si necesita servicios de recuperación u otras necesidades especiales				
Servicios de recuperación de las habilidades	No cubierto	No cubierto	Servicio excluido	
Cuidado de enfermería especializado	\$100 de copago/días, 1-5 días	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 30 días/año.	
Equipo médico duradero	\$0	No cubierto	Necesita autorización previa para cobertura.	
Cuidado de hospicio	\$0	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 210 días/de por vida.	
Si su hijo necesita servicios dentales o de la vista	Examen de la vista Anteojos	\$0 \$29 de copago por marcos monofocales	No cubierto No cubierto	Limitado al pruebas de detección de rutina en el consultorio del PCP. Cobertura limitada a un par de anteojos anual.
Consulta dental		\$0	No cubierto	Cobertura limitada a una limpieza cada 6 meses.

Preguntas: Llame al 1-866-847-8235 o visite www.chcfflorida.com.

Si no entiende alguno de los términos en negritas, consulte el Glosario en www.cciio.cms.gov o llame al 1-866-847-8235 y pida una copia. **5 de 8 - Spanish**

Coventry Health Care of Florida: FDCOAX4-40 \$5000

Duración de la póliza: 01/01/2013 – 12/31/2013
Resumen de beneficios y cobertura: Lo que cubre el plan y los precios Cobertura de: EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | Tipo de plan: HMO

Servicios excluidos y otros servicios cubiertos:

Los servicios que su plan NO cubre. (Esta es una lista parcial. Consulte los documentos del plan para más información.)

- Acupuntura
- Cirugía bariátrica
- Cirugía estética
- Aparatos auditivos
- Tratamiento de infertilidad
- Cuidados prolongados
- Atención que no sea de emergencia al viajar fuera de EE.UU.
- Atención de enfermería privada
- Programas para bajar de peso

Otros servicios cubiertos. (Esta es una lista parcial. Consulte los documentos del plan para otros servicios cubiertos y sus precios)

- Atención de quiropráctico
- Atención rutinaria de la vista (Adulto)
- Atención rutinaria del pie (si se receta a diabéticos)

Su derecho para continuar con la cobertura:

Si pierde la cobertura bajo el plan, dependiendo de las circunstancias, las leyes federales y estatales pueden brindarle protecciones que le permiten tener cobertura de salud. Tales derechos pueden ser limitados en duración y se le exigirá que usted pague una **prima**, que puede ser significativamente mayor que la prima que paga al estar cubierto por el plan. También puede aplicar otras limitaciones en sus derechos para continuar la cobertura. Para más información sobre sus derechos para continuar la cobertura, comuníquese con el plan al **1-866-847-8235**. También puede llamar al departamento de seguros de su estado, al Departamento del Trabajo de EE.UU., a la Administración para la Seguridad de los Beneficios del Trabajador al 1-866-444-3272 o www.dol.gov/ebsa, o al Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-267-2323 ext.61565 o www.ccio.cms.gov.

Su derecho a presentar una queja o una apelación:

Si tiene una queja o no está satisfecho con una negación de cobertura por reclamaciones hechas bajo su plan, puede apelar o presentar una queja formal. Para preguntar sobre sus derechos, este aviso o solicitar ayuda, puede llamar al: plan al **1-866-847-8235**. También puede llamar al departamento de seguros de su estado, al Departamento del Trabajo de EE.UU., a la Administración para la Seguridad de los Beneficios del Trabajador al 1-866-444-3272 o www.dol.gov/ebsa/healthreform, o al Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-267-2323 ext.61565 o www.ccio.cms.gov.

Servicios de acceso a idiomas:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-847-8235.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-847-8235.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-847-8235.
Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-866-847-8235.

Para ejemplos sobre cómo este plan paga por los servicios en una situación médica específica consulte la página siguiente.

Preguntas: Llame al **1-866-847-8235** o visite www.chcflorida.com.
Si no entiende alguno de los términos en negritas, consulte el Glosario en www.ccio.cms.gov o llane al **1-866-847-8235** y pida una copia. **6 de 8 - Spanish**

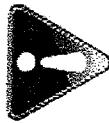
Coventry Health Care of Florida: FDCOAX4-40 \$5000

Ejemplos de cobertura

Duración de la póliza: 01/01/2013 – 12/31/2013
Cobertura de: EE, EE/Spouse, EE/Child(ren), EE/Family | **Tipo de plan:** HMO

Sobre los ejemplos de cobertura:

Estos ejemplos le muestran cómo cubriría el plan los servicios en situaciones distintas. Úselos para tener una idea de cuánta cobertura económica podría obtener el paciente del ejemplo de los distintos planes.



Ésta no es una herramienta de cálculo de costos

No use estos ejemplos para calcular los costos reales de su plan. Los servicios médicos que usted reciba y los precios pueden ser distintos a los mencionados en los ejemplos.

Para información importante sobre estos ejemplos, consulte la página siguiente.

Nacimiento (parto normal)

- **El proveedor cobra:** \$7,540
- **El plan paga:** \$2,743
- **Usted paga:** \$4,797

Ejemplos de los costos:

El costo del hospital (madre)	\$2,700
Atención de rutina del obstetra	\$2,100
El costo del hospital (bebé)	\$900
Anestesia	\$900
Analisis de laboratorio	\$500
Medicamentos	\$200
Radiografías	\$200
Vacunas y otros servicios preventivos	\$40
Total	\$7,540

Control de la diabetes (control rutinario de la enfermedad)

- **El proveedor cobra:** \$5,400
- **El plan paga:** \$3,454
- **Usted paga:** \$1,946

Ejemplo de los costos:

Medicamentos	\$2,900
Equipo médico e insumos	\$1,300
Visitas al consultorios y procedimientos médicos	\$700
Educación sobre el cuidado	\$300
Analisis de laboratorio	\$100
Vacunas y otros servicios preventivos	\$100
Total	\$5,400

El paciente paga:

Deductibles	\$0
Copagos	\$1,907
Coseguro	\$0
Límites o exclusiones	\$39
Total	\$1,946

Preguntas y respuestas sobre los ejemplos mencionados:

¿Qué conceptos se presuponen de estos ejemplos?

- Los costos no incluyen las **primas**.
- Los ejemplos de costos están basados en los promedios nacionales provenientes del Departamento de Salud y Servicios Humanos de los EE.UU. y que no son específicos para una zona geográfica o un plan.
- La afección del paciente no es una condición excluida ni preexistente.
- Todos los servicios y tratamientos empezaron y terminaron en el mismo período de cobertura.
- No hay otros gastos médicos para ningún miembro cubierto por este plan.
- Los gastos del bolsillo están basados solamente en el tratamiento del problema mencionado en el ejemplo.
- El paciente recibió todos los servicios de proveedores de la red del plan. Si el paciente hubiese recibido los servicios de **proveedores** fuera de la red, los costos hubieran sido más altos.

¿Qué muestra el ejemplo?

En cada ejemplo usted verá cómo suman los **deductibles, copagos y coseguro**. También le ayudan a ver cuáles son los gastos que tendrá que pagar usted porque no están cubiertos o porque el pago es limitado.

¿Contempla el ejemplo mis propias necesidades?

X **No.** Los tratamientos que mencionamos son solo ejemplos. El tratamiento que usted podría recibir para esta condición tal vez sea distinto, según cuál sea el consejo de su médico, su edad, la gravedad de su caso y otros factores.

¿Puede el ejemplo predecir mis gastos futuros?

X **No.** Los ejemplos de cobertura **no** son herramientas de cálculo de costos. Usted no puede usar el ejemplo para estimar el costo del cuidado de su condición. El ejemplo es únicamente para fines comparativos. Sus costos reales dependerán de los servicios que reciba, del precio del **proveedor** y del reembolso que autorice el plan.

¿Puedo usar los ejemplos para comparar los planes?

✓ Sí. Cuando usted se fija en el Resumen de Beneficios y Cobertura de otros planes, encontrará los mismos ejemplos de cobertura. Cuando compate los planes, fíjese en el casillero titulado “Usted paga” de cada ejemplo. Cuanto más bajo el número, mayor será la cobertura ofrecida por el plan.

¿Debo tener en cuenta otros costos al comparar los planes?

✓ Sí. Un gasto importante es lo que paga de **prima**. Por lo general, cuanto más baja sea la **prima** mayores serán los gastos de su bolsillo, como los **copagos, deductibles** y **coseguro**. También debe tener en cuenta las contribuciones a cuentas tales como las Cuentas de Ahorros Médicos (HSA), Acuerdos de Gastos Flexibles (FSA) o las Cuentas de Reembolsos Médicos (HRA) que le ayudan con los gastos del bolsillo.

Supplemental Limited Benefit Medical Expense Insurance MEDlink®IV – Enhanced Plus

Summary of Benefit for City of Hialeah

Medical Benefits	
Basic Policy	
Maximum In-Hospital Benefits	\$4,500 per Covered Person per Calendar Year. Maximum of \$13,500 per Calendar Year for all Covered Persons combined.
In-Hospital Ambulance Benefit	Up to \$350 per trip for ground transportation or up to \$1,000 per trip for air transportation where a Covered Person is Confined as an Inpatient. Limited to one trip per day.
Pre-Existing Period	The Pre-Existing Period is 12 months prior to the effective date of coverage. This product has a Pre-Existing Condition Limitation. The Pre-Existing Condition Limitation will apply only if the Covered Person is subject to a Pre-Existing Condition Limitation under the Other Medical Plan. Therefore, any Pre-Existing Condition Limitation applied to the Major Medical plan would, in effect, limit coverage under this plan.
Outpatient Benefits	
Maximum Outpatient Benefits	\$250 per Covered Person per Calendar Day for Covered Outpatient Services.
Outpatient Ambulance Benefit	Up to \$350 per trip for ground transportation or up to \$1,000 per trip for air transportation where a Covered Person resides less than 18 hours. Limited to one trip per day.
Covered Outpatient Services	
Hospital Emergency Room	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Urgent Care Facility	Maximum of three Urgent Care visits per Covered Person per Calendar Year. Maximum of six Urgent Care visits per Calendar Year for all Covered Persons combined. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Outpatient Surgery	Outpatient Surgery in Hospital Outpatient Facility or Freestanding Outpatient Surgery Center. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Diagnostic Testing	Diagnostic Testing in a Hospital Outpatient Facility or MRI Facility. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Outpatient Treatment for a Mental or Emotional Disorder in a Hospital Outpatient Facility	Maximum of 30 days of treatment per Covered Person per Calendar Year. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Cancer Treatment Facility	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Physical Therapy Facility	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.

Premiums*

Billed Monthly Premiums by Plan				
	Employee	Employee & Spouse	Employee & Child	Employee & Family
Ages 18-54	\$14.10	\$25.38	\$27.49	\$38.77
Ages 55+	\$21.15	\$38.07	\$34.54	\$51.46

*The Premium and amount of benefits vary dependent upon the plan selected.

Must be used in conjunction with brochure APSB-22133 series

Supplemental Limited Benefit Medical Expense Insurance MEDlink®IV – Enhanced Plus

Summary of Benefit for City of Hialeah

Medical Benefits	
Health Policy	
Maximum In-Hospital Benefits	\$10,000 per Covered Person per Confinement.
In-Hospital Ambulance Benefit	Up to \$350 per trip for ground transportation or up to \$1,000 per trip for air transportation where a Covered Person is Confined as an Inpatient. Limited to one trip per day.
In-Hospital Deductible	\$0 per Covered Person per Confinement
Pre-Existing Period	The Pre-Existing Period is 12 months prior to the effective date of coverage. This product has a Pre-Existing Condition Limitation. The Pre-Existing Condition Limitation will apply only if the Covered Person is subject to a Pre-Existing Condition Limitation under the Other Medical Plan. Therefore, any Pre-Existing Condition Limitation applied to the Major Medical plan would, in effect, limit coverage under this plan.
Covered Outpatient Services	
Maximum Outpatient Benefits	\$250 per Covered Person per Calendar Day for Covered Outpatient Services.
Outpatient Ambulance Benefit	Up to \$350 per trip for ground transportation or up to \$1,000 per trip for air transportation where a Covered Person resides less than 18 hours. Limited to one trip per day.
Outpatient Deductible	\$0 per Covered Person per Calendar Day
Covered Outpatient Services	
Hospital Emergency Room	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Urgent Care Facility	Maximum of three Urgent Care visits per Covered Person per Calendar Year. Maximum of six Urgent Care visits per Calendar Year for all Covered Person combined. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Outpatient Surgery	Outpatient Surgery in Hospital Outpatient Facility or Freestanding Outpatient Surgery Center. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Diagnostic Testing	Diagnostic Testing in a Hospital Outpatient Facility or MRI Facility. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Outpatient Treatment for a Mental or Emotional Disorder in a Hospital Outpatient Facility	Maximum of 30 days of treatment per Covered Person per Calendar Year. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Cancer Treatment Facility	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Physical Therapy Facility	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.

Premiums*

GAP with HMO Low Option				
	Employee	Employee & Spouse	Employee & Child	Employee & Family
Ages 18-54	\$18.72	\$33.70	\$36.50	\$51.48
Ages 55+	\$28.08	\$50.54	\$45.86	\$68.33

*The premium and amount of benefits vary dependent upon the plan selected.

Must be used in conjunction with brochure APSB-22133 series



HUMANA.
Specialty Benefits

Great News!

New Humana Vision Care Plan for the City of Hialeah Employees

Benefits for employees & family members include:

- Comprehensive Eye Exams at listed co-pays
- Private Practice Providers
- Frames and Lenses at listed co-pays
- Coverage for Contact Lenses
- Discounts for Lasik Surgery
- Newly Expanded Vision Network

**Ask us how
YOU CAN ENROLL TODAY!**



Please visit our website at
www.humanavisioncare.com

Member Services 800-979-4578



See the difference a HumanaVision plan can make for you

Periodic eye exams are an important part of routine preventive healthcare. Because many eye and vision conditions have no obvious symptoms, you may be unaware of problems. Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss.*

HumanaVision offers:

- **Access to a huge network** — Choose from more than 35,000 participating optometrist, ophthalmologist, and national retail locations, including LensCrafters®, Pearle Vision®, Sears® Optical, Target® Optical, and JCPenney® Optical.
- **Cost-savings** — get deep discounts (wholesale pricing) no matter which in-network provider you choose. Plus, you'll receive discount on LASIK procedures.
- **Choice** — You have access to exclusive lines of designer frames, such as:



- **Convenience** — Take care of eye exams and frames all in one visit. Many locations offer night and weekend appointments to fit your schedule.

Vision care impacts overall health

Eye exams not only help your vision, your doctor can catch major health issues, too. Many diseases can be diagnosed by looking into your eyes including diabetes, multiple sclerosis, high blood pressure, and high cholesterol.

For more information, go to HumanaVisionCare.com



LENSCRAFTERS®

PEARLE VISION®

Sears
Optical

OPTICAL



*American Optometric Association

**CITY OF HIALEAH, FLORIDA
RISK MANAGEMENT DIVISION
MEMORANDUM**

To: All Members currently enrolled in the City's Self Funded Group Health Plan
From: Robert Lloyd-Still, Risk Manager
Date: October 11, 2012
Subject: Medicare Part D Prescription Coverage

**Important Notice from the City of Hialeah Self-Funded Group Health Plan About
Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Hialeah Self-Funded Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
 2. The City of Hialeah has determined that the prescription drug coverage offered by the City of Hialeah Self-Funded Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
-

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Hialeah Self-Funded Plan coverage will not be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your City of Hialeah Self-Funded Plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Hialeah Self-Funded Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...

Contact our office at 305-883-8059 for further information or call United Healthcare at 1-800-842-2038. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the City of Hialeah Self-Funded Plan changes. You may also request a copy at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	<i>October 11, 2012</i>
Name of Entity/Sender:	<i>City of Hialeah Self-Funded Plan</i>
Contact--Position/Office:	<i>Risk Management Office</i>
Address:	<i>501 Palm Avenue, Hialeah, Florida 33010</i>
Phone Number:	<i>305-883-8059</i>

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http://www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268

NOTICE ABOUT THE
EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.